

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LTC Residents Protection
JAN 21 2009
Director's Office
PRINTED: 12/22/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/10/2008
NAME OF PROVIDER OR SUPPLIER GILPIN HALL			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GILPIN AVENUE WILMINGTON, DE 19806		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from December 2, 2008 through December 10, 2008. The deficiencies cited in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census the first day of the survey was 95. The survey sample totaled nineteen (19) residents, which included sixteen (16) active and three (3) closed clinical records. Additionally, there were nine (9) subsampled residents in which full record reviews were not completed.	F 000			
F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to post a notice as to the availability of the results of the most recent survey. Findings include: During the initial tour of the facility on 12/2/08, the results from the last annual and complaint survey were observed in a rack located in the lobby;	F 167 F167	1.1 Notices have been posted in resident accessible areas. 1.2 All residents may be affected. 1.3 Notices have been posted in resident accessible areas (near dining room entrance doors). Administrator or designee will check monthly to ensure postings are intact. 1.4 Administrator or designee will report to QA that posting are present.		1/30/09 1/30/09 1/30/09 1/30/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 167	Continued From page 1	F 167			
F 240 SS=E	<p>however, there were no notices posted on the resident floors to indicate the availability of the survey results.</p> <p>483.15 QUALITY OF LIFE</p> <p>A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and resident interviews it was determined that the facility failed to care for its residents in a manner and in an environment that promoted maintenance or enhancement of each resident's quality of life with regard to the dining experience. All residents were not provided with information regarding the daily menu. Additionally, five residents (#13, SS#21, #SS22, #SS23, #SS24) were not offered beverages with their meals in the second and third floor dining rooms. Findings include:</p> <p>1. Observations during the first five days of the survey revealed that the weekly menu was not posted in an area accessible for residents to view.</p> <p>(a) On 12/4/08 Resident #SS28 who was alert and oriented was entering the dining room to eat lunch and was asked how she knew what was being served. She stated that she did not know until the meal was served to her and that she did not have a copy of the menu.</p> <p>(b) Resident #15 was observed on 12/3/08 at 12:05 PM in the dining room with an untouched</p>	F 240 F240	<p>1.1 Current menus including alternates will be posted in an area accessible for residents to review. (outside dining room main entrance)</p> <p>1.2 All residents are affected.</p> <p>1.3 Dietary Manager or designee will post and check daily that menus are accessible for residents to review.</p> <p>1.4 Dietary Manager will report presence of current menus with alternates during QA.</p> <p>2.1 Dietary and Nursing staff will be inserviced to encourage liquids and serve thickened liquids during meals.</p> <p>2.2 All residents may be affected.</p> <p>2.3 Dietary Manager or designee will observe a sampling of meals daily and complete "Dining Room Checklist" form.</p> <p>2.4 Dietary Manager or designee will report a summary report of "Dining Room Checklist" to QA team.</p>	<p>1/30/09</p> <p>1/30/09</p> <p>1/30/09</p> <p>1/30/09</p> <p>1/30/09</p> <p>1/30/09</p> <p>1/30/09</p>	

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F 240	<p>Continued From page 2</p> <p>plate of food. When asked why she had not eaten her lunch, she stated that she did not like what was served. When asked if she requested the alternate, she stated that she didn't know that anything else was available.</p> <p>Cross refer F241, example #4</p> <p>2. (a) On 12/3/08 at 8:00 AM, Resident SS#21 was observed seated in the dining room eating breakfast. A dietary aid poured her a glass of juice which she drank all at once. She fed herself a bowl of cereal and some prunes. Twenty-five minutes later, CNA#6 was observed bringing her a hot meal and proceeded to assist the resident with eating. Resident SS#21 was not offered anything else to drink for the duration of the meal.</p> <p>(b) On 12/4/08 at 8:20 AM, Resident #13 was observed drinking her entire beverage before being served her entree. She then ate dry waffles with her hands and was not offered an additional beverage for the remainder of the meal.</p> <p>(c) Residents SS#22, SS#23 and SS#24 were observed seated at the same table for the lunch meal on 12/2/08 at approximately 12 PM. Residents SS#22 and SS#23 were fed by nursing staff and Resident SS#24 required frequent cueing and was mainly fed by staff. All 3 residents were on nectar thickened liquids and had plastic coffee cups turned upside down by their plates.</p> <p>Resident SS#23 was fed her entire meal and was finished for about 20 minutes without having anything to drink. The other 2 residents also did not have anything available to drink. The surveyor advised a kitchen staff member walking near the</p>	F 240			

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F 240	Continued From page 3 table about 12:20 PM that Residents SS#22, SS#23 and SS#24 had nothing to drink. The kitchen staff member replied that nursing had to get thickened liquids. Staff interviews did not reveal that there was a system in place to assure that residents on thickened liquids received beverages with their meals. At approximately 12:30 PM, CNA #1 brought a large container of pre-thickened cranberry juice for the 3 residents which she poured into the coffee cups. Resident SS#24 drank 1/2 of the cup of juice independently as soon as the juice was poured. The residents were not heard conversing during the meal, so it is uncertain as to whether they would be able to ask for a drink or state that they were thirsty.	F 240			
F 241 SS=E	Findings were discussed with administrative staff on 12/9/08. 483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that 1 (Resident #4) out of 19 sampled residents was appropriately covered and treated in a dignified manner while care was being provided. Additionally, the facility failed to ensure that all residents were treated in a dignified manner during meals. Observations were made of staff standing to feed residents during breakfast and lunch meals with minimal verbal interaction for 7 (Resident's #10, #12, SS#20, SS#21, SS#22, SS#25, SS#27) residents.	F 241			

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F 241	Continued From page 4 A visually impaired resident (Resident #13) was not appropriately set up and assisted with meals. Also, an observation was made of staff beginning to clear the table prior to Resident #6's completion of the meal. Residents SS#22, SS#23 and SS#24 sat at the same table with their meals before them but Resident's #22 and #24 waited a half an hour or more to be assisted or fed while Resident SS#23 was being fed. Additionally, an observation was made of a frayed tablecloth being used in the 3rd floor dining area on two occasions. Findings include: 1. On 12/4/08, during observation of a wound care treatment, Resident #4 was not appropriately covered exposing the genital area. This was confirmed by LPN #1 who was providing the care on 12/4/08 and with the Director of Nursing on 12/9/08. 2. The following observations involved staff feeding residents while standing up with little or no conversation observed in the third floor dining room: A. - On 12/2/08, LPN #1 was observed standing up and feeding lunch to Resident SS#25. On 12/4/08, LPN #2 was also observed standing up and feeding lunch to Resident SS#25; B. - On 12/3/08, CNA #2 was observed standing up and feeding breakfast to Resident #12; C. - On 12/3/08, CNA #3 was observed standing up and feeding breakfast to Resident SS#20; D. - On 12/4/08, CNA #4 was observed standing up and feeding lunch to Resident #10; E. - On 12/4/08, CNA #5 was observed	F 241	1.1 Resident #4 will be covered during all treatments. 1.2 All resident may be affected. 1.3 Nursing staff will be inserviced on resident dignity issues. Sampling of dressing changes will be observed by DON or designee. 1.4 Results of observations will be reported to the QA. 2.1 Residents are fed meals with staff seated. 2.2 All residents may be affected. 2.3 Dietary Manager or designee will observe a sampling of meals daily and complete "Dining Room Checklist" form. 2.4 Dietary Manager or designee will report a summary report of "Dining Room Checklist" to QA team.		1/30/09 1/30/09 1/30/09 1/30/09 1/30/09 1/30/09 1/30/09

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F 241	Continued From page 5 standing up and feeding lunch to Resident SS#27; F. - On 12/3/08, LPN #4 was observed standing up and feeding lunch to Resident SS#22. cross refer to F240, example #2 (c) 3. Residents SS#22, SS#23 and SS#24 were observed seated at the same table for the lunch meal on 12/2/08. Residents SS#22 and SS#23 were fed by nursing staff and Resident SS#24 required frequent cueing and was mainly fed by nursing staff. Residents SS#22 and SS#24 sat at the table while Resident SS#23 was fed by a staff member. Approximately 30 minutes after Resident SS#23 completed her meal, CNA #1 began feeding Resident SS#22. CNA #1 fed Resident SS#22 her entire meal while standing closely to the resident and with her back to Resident SS#23. An empty chair was available at the table for use. CNA #1 was not heard conversing with Resident SS#22 while feeding her. Resident SS#24 was fed last. 4. On 12/3/08 at 8:00 AM, Resident SS#21 was observed seated in the dining room at a table with three other residents. She was observed feeding herself a bowl of cereal and some prunes which she finished. The other three residents were served a hot breakfast while Resident SS#21 sat and watched them eat. Twenty-five minutes later, CNA#6 was observed bringing Resident SS#21 a hot meal and proceeded to feed her while standing, without speaking to her. A few minutes later, CNA#6 was observed pulling up a chair next to the resident to finish feeding her. 5. Frayed tablecloths were observed in the third floor dining room on 12/2/08 and 12/4/08.	F 241 F241	3.1 Residents are fed meals with staff seated and residents who require will receive cueing as directed. 3.2 All residents may be affected. 3.3 Dietary Manager or designee will observe a sampling of meals daily and complete "Dining Room Checklist" form. 3.4 Dietary Manager or designee will report a summary report of "Dining Room Checklist" to QA team. 4.1 Resident will served meals in a timely manner and staff will remain seated while feeding. 4.2 All residents may be affected. 4.3 Dietary Manager or designee will observe a sampling of meals daily and complete "Dining Room Checklist" form. 4.4 Dietary Manager or designee will report a summary report of "Dining Room Checklist" to QA team.	1/30/09 1/30/09 1/30/09 1/30/09 1/30/09 1/30/09 1/30/09 1/30/09	

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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7M3711 Facility ID: DE0075 If continuation sheet Page 7 of 23

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F 241	Continued From page 7 On 12/3/08 at 12:25 PM, Resident #13 was observed seated at a table in the third floor dining room with an entree in front of her. Unable to see, she was feeling around for the food and beverage. She ate a roll and drank a cup of juice. She could not locate the utensils and did not eat the entree. No staff were observed assisting Resident #13 with her meal. On 12/9/08, the dining concerns were addressed with the Executive Administrator, Administrator, Director of Nursing, and the Food Services Director.	F 241			
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to accommodate the needs of one resident, (#15) out of 19 sampled and one other subsampled resident (#SS26). Resident #15 was not provided with small meal portions per her diet card. Resident #SS26 was not positioned at the dining table so that she could easily reach her meal. Findings include: 1. Review of Resident #15's clinical record revealed a history of weight loss. She had a care	F 246			
		F246	1.1 Resident will be served appropriate portions and positioned properly. 1.2 All residents may be affected. 1.3 Dietary Manager or designee will observe a sampling of meals daily and complete "Dining Room Checklist" form. 1.4 Dietary Manager or designee will report a summary report of "Dining Room Checklist" to QA team.		1/30/09 1/30/09 1/30/09 1/30/09

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F 246	<p>Continued From page 8</p> <p>plan for a "Potential for Weight Loss" which was last updated on 5/19/08 and called for small portions. Nutritional Progress Notes, dated 10/16/08, also called for small portions. Additionally, her diet card on the table where she sits in the dining room also indicated that she was to receive small portions.</p> <p>During dining observations on 12/3/08 and 12/4/08, Resident #15 was observed receiving full meal portions at lunch. On 12/5/08, she was observed receiving a full meal portion at breakfast. Interview with the Food Service Director revealed that Resident #15 should have been receiving small portions if it was noted on her diet card.</p> <p>At lunch time on 12/5/08, Resident #15 received a small portion.</p> <p>During dining observations on 12-4-08 at 12:15 PM Resident #SS26 was brought to the dining room in a wheelchair and positioned sideways at the dining table. Her entree, beverage and utensils were too far for her to reach. She managed to reach a lemon slice off her plate and sucked on it. No staff assisted Resident #SS26 for 11 minutes. A staff member then moved the items closer to Resident #SS26 however, she ate her meal while facing sideways to the table.</p> <p>On 12-5-08 at 8:30 AM Resident #SS26 was observed at the dining table facing sideways in her wheelchair reaching for her food. Her entree was too far for her to reach. At the surveyors request a staff member properly adjusted the resident's wheelchair so she could eat her meal.</p> <p>The findings were discussed with administration on 12-9-08.</p>	F 246			

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F 279 SS=D	<p>483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to develop care plans to meet residents' medical and nursing needs based on their comprehensive assessments for 1 (Resident #4) of 19 sampled residents. Findings include:</p> <p>Resident #4 was admitted to the facility with depression and other medical conditions. A Minimum Data Set (MDS) admission assessment, dated 9/16/08, revealed Resident Assessment Protocols which indicated the need for care plans to be developed in the areas of</p>	F 279 F279	<p>1.1 Care plan for the identified items has been added.</p> <p>1.2 All residents may be affected.</p> <p>1.3 A sampling of MDS/care plans will be reviewed quarterly by DON or designee to determine that the appropriate care plan is in place.</p> <p>1.4 Findings of the review will be reported to the QA.</p>		<p>1/30/09</p> <p>1/30/09</p> <p>1/30/09</p> <p>1/30/09</p>

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F 279	Continued From page 10 cognitive loss and psychotropic drug use. The facility failed to develop care plans in those areas.	F 279			
F 309 SS=D	On 12/4/08, findings were confirmed with the RN Assessment Coordinator who then developed the care plans for cognitive loss and psychotropic drug use. 483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of other documentation as necessary, observation, and interview, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 3 (Residents #13, #15 and #17) out of 19 sampled residents. The facility failed to follow Resident #13's care plan to notify the MD and RD (Registered Dietitian) of a significant weight loss of 7.9% in one month and they failed to provide interventions for 21 days, additionally, they failed to follow the resident's care plan to explain location of food placement for all meals, and assist with meals as needed. The facility failed to provide Resident #15 with ice cream as ordered with meals. The facility failed to transcribe all of the wound treatment orders onto	F309 F 309	1.1 Resident has expired. 1.2 All resident may be affected. 1.3 A sampling of new orders will be reviewed by DON or designee weekly to confirm proper transcription of order. (A new Pharmacy tracking system has been in place since Oct 2008.) 1.4 Findings of the review will be reported to the QA. 2.1 Resident will be offered ice cream with meals. 2.2 All residents may be affected. 2.3 Dietary Manager or designee will observe a sampling of meals daily and complete "Dining Room Checklist" form. 2.4 Dietary Manager or designee will report a summary report of "Dining Room Checklist" to QA team.	1/30/09 1/30/09 1/30/09 1/30/09 1/30/09 1/30/09 1/30/09	

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NAME OF PROVIDER OR SUPPLIER GILPIN HALL			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GILPIN AVENUE WILMINGTON, DE 19806		
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F 309	Continued From page 11 the TAR (treatment administration record) for Resident #17 and to consistently provide correct treatments. Findings include: 1. Resident #17 was admitted to the facility in 2004 with diagnoses including dementia, multiple cardiac problems and PVD (peripheral vascular disease). Review of significant change MDS (minimum data set) assessments, dated 8/7/07 and 1/15/08, stated that Resident #17 was moderately impaired in cognitive skills for daily decision-making with long and short-term memory impairment. She was totally dependent on staff for activities of daily living and non-ambulatory. On 10/19/07, a podiatry note stated that the podiatrist avulsed (removal of part of the nail) an ingrown toenail on the left great (big) toe that was digging into the skinfold. Wound care was ordered on 10/19/07 to clean the toe with saline and to apply a dressing daily. In a nurse's note, dated 11/13/07, the wound care (wc) nurse noted that the wound was not responding to treatment (tx) and recommended that the tx be changed to Silvadene. The wound was staged as a "3" (full thickness skin loss involving damage to, or necrosis (tissue death) of, subcutaneous tissue that may extend down to underlying fascia- presents clinically as a deep crater). Review of the TAR revealed that the facility incorrectly administered both the previous tx of saline and a dressing (ordered 10/19/07) and Silvadene on 12/1 and 12/2/07. In a nurse's note, dated 12/4/07, the wc nurse	F 309 F309	3.1 Resident now receives assistance with meals. Dietician and MD are aware of weight loss. 3.2 All residents may be affected. 3.3 Dining room checklist will be completed by Dietary Manager or designee. Dietician will be notified of all weight changes of 5lbs or greater within 1 week of weight change. 3.4 Dietary Manager will report findings of Dining Room Checklist to QA. DON or designee will report weight loss of 5lbs or more to QA.		1/30/09 1/30/09 1/30/09 1/30/09

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F 309	<p>Continued From page 12</p> <p>stated, "... toe wound non healing... Recommend Panafil- also for podiatry to re-evaluate." These recommendations were supported with physician orders. Review of the TAR (treatment administration record), revealed that the facility failed to implement Panafil as ordered; the facility incorrectly continued to administer Silvadene from 12/5/07 through 12/9/07. No tx was administered on 12/10/07.</p> <p>In a nurse's note, dated 12/11/07, the wc nurse recommended that the MD and podiatrist reevaluate Resident #17's wound. Wound Care recommendations were written (and signed by the physician) on 12/11/07 to discontinue Panafil and change the tx to Silvadene with Zinc Oxide to surrounding skin. On 12/12/07, the MD wrote in a progress note that the toe had increased redness. He also stated that Panafil was discontinued and tx was changed. As evident in the wc nurse's and MD's statements, it was unknown to them that Resident #17 had not received Panafil tx's as ordered on 12/4/07. Consequently, a decision was made to change the tx to Silvadene, the same tx that the wound had not improved with and that Resident #17 had incorrectly received until 12/9/07.</p> <p>On 12/14/07, Resident #17 was reevaluated by the podiatrist. Progress notes stated, "... has been on panafil ointment as per wound care nursing for a few weeks... applied a wet to dry dressing. Nursing to continue daily wound care to toe." The podiatrist received incorrect information (that the resident had been receiving Panafil) and based his tx decision accordingly. Physician orders were written on 12/14/07 per the podiatrist's recommendations to discontinue previous tx and to start wet to dry saline tx's daily.</p>	F 309			

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F 309	<p>Continued From page 13</p> <p>On 12/18/07, the wc nurse stated in a nurse's note, "... Continues on Silvadene (tx should have been changed to saline wet to dry dressings on 12/14/08)... Recommend (name of MD) reevaluate and consider... WCC (wound care center)." On 12/19/07, the MD stated in a progress note that the toe wound was not responding to tx despite wound care and podiatric tx. He suggested, "... send to the WCC (sic) Agree on Augmentin (antibiotic) & wet to dry...". Review of the 12/07 TAR revealed that the facility failed to transcribe and implement the podiatrist's order for wet to dry dressings ordered on 12/14/07. The facility failed to discontinue the previous tx and incorrectly continued to administer Silvadene and Zinc Oxide.</p> <p>On 12/27/07, Resident #17 was evaluated at the WCC. The left toe was gangrenous at this time. A tx order was written on 12/27/07 for Panafil daily. Review of the TAR revealed that the facility failed to discontinue the Silvadene and Zinc Oxide when the order changed to Panafil on 12/27/07; as a result, the facility incorrectly administered both Silvadene/Zinc oxide and Panafil from 12/28/07 to 12/30/07.</p> <p>A podiatry progress note, dated 12/31/07, stated, "... hallux (big toe) started to become dusky and then black in color last week...". Review of the TAR revealed that the facility incorrectly provided tx with Silvadene and Zinc Oxide (ordered to be discontinued on 12/14/07) on 1/1/08 instead of Panafil, recommended by the WCC.</p> <p>Resident #17 was hospitalized from 1/2 to 1/8/08 with a gangrenous left great toe. Vascular studies done at the hospital on 1/2/08 revealed that</p>	F 309			

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F 309	<p>Continued From page 14</p> <p>Resident #17 had significant bilateral arterial disease with no pulses in either foot. A vascular surgeon was consulted on 1/4/08 and stated, "... If her pain can be controlled... would not recommend surgical intervention, revascularization or amputation... above the knee level... do not believe she would have healing...". Resident #17's family opted not to amputate her leg.</p> <p>Resident #17 returned to the facility on 1/8/08 on hospice and expired on 1/19/08 from septicemia due to an infected foot wound.</p> <p>In summary, the facility failed to transcribe wound tx orders from the facility wc nurse and the podiatrist, failed to discover the transcription errors in the 24 hour chart checks and failed to administer correct wound tx's repeatedly. As a result, incorrect tx decisions were made. However, Resident #17 lacked the potential to heal due to severe vascular/circulation problems.</p> <p>Findings were confirmed with the Executive Nursing Home Administrator (NHA), NHA, and Director of Nursing on 12/9/08.</p> <p>2. Review of Resident #15's Physician's Order Sheet, dated 12/08, revealed an order for ice cream at 12:00 noon and 5:00 PM (with meals). Her care plan for "Potential for Weight Loss", last updated on 10/9/08 also indicated ice cream twice a day.</p> <p>Observations of Resident #15 at lunch on 12/3/08, 12/4/08 and 12/5/08, revealed that she did not receive nor was she offered ice cream with her meals.</p>	F 309			

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F 309	<p>Continued From page 15</p> <p>In an interview with the Assistant Director of Nursing (ADON) on 12/5/08, she stated if a resident has an order for ice cream with meals that dietary gives it to the resident, but nursing records it on the Medication Administration Record (MAR). When asked how the order is communicated to dietary, she stated that the orders are given to dietary and then written on the resident's diet card at their place in the dining room. Examination of Resident #15's diet card revealed no order for ice cream.</p> <p>Findings were confirmed by the ADON.</p> <p>Cross-refer F241 example #7</p> <p>3. Resident #13 was admitted to the facility on 6/1/06 with diagnoses that included Glaucoma, Hypertension, Gastric reflux, Dementia, and CVA (Stroke). Review of Resident #13's care plan entitled, Impaired visual function, included the intervention "Explain location of food placement for all meals". Additionally, her care plan entitled, Potential for weight loss dated 10/17/08 stated, "Notify MD (medical doctor) and RD (registered dietitian) of weight loss +/- 5 lbs (plus or less than 5 pounds) in 30 days or less" and, "staff assist with meals as needed."</p> <p>Dining observations on 12/3/08 and 12/4/08 revealed that staff failed to explain the location of food placement during breakfast and lunch. Resident #13 was observed feeling her plate for food. She was trying to pick up noodles and chicken that were too hot and slippery for her to pick up with her hands.</p> <p>According to the facility's Monthly Weight Report sheet for 9/16/08, Resident #13's weight was 101 lbs. On 10/25/08 her weight was noted to be 93</p>	F 309			

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F 309	Continued From page 16 lbs, eight pounds less then the previous month. Review of clinical records revealed that the facility failed to notify the MD or RD for 21 days after the weight loss was identified. Consequently it was 21 days before the registered dietician ordered 2 CAL HN supplement for this resident who sustained a 7.9% weight loss. The facility failed to follow the care plan by failing to notify Resident #13's physician or the RD of the 7.9% weight loss within one month. Additionally, the facility failed to ensure Resident #13 received the assistance this visually impaired resident required including the explanation and the location of food placement at meals. An interview with the ADON (Assistant Director of Nursing) on 12/9/08 confirmed the findings.	F 309			
F 313 SS=D	483.25(b) VISION AND HEARING To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to provide or obtain vision services to meet the needs of 1 (Resident #7) of 19 residents in the sample. Findings include:	F 313			
		F313	1.1 Resident has been treated by Ophthalmologist for Glaucoma. 1.2 All residents may be affected. 1.3 Policy created 6/2008 that guides scheduler to ensure that routine Dr. appointments are made for each resident. 1.4 DON or designee will report missed appointments to QA.		1/30/09 1/30/09 1/30/09 1/30/09

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F 313	Continued From page 17 Resident #7 was admitted to the facility on 12/8/97 with diagnoses that included glaucoma, dementia, hypertension, peripheral vascular disease and seizure disorder. According to clinical records Resident #7 was treated yearly for glaucoma since 2002 with follow-up visits every 3 to 4 months. On 5/26/06 Resident #7 had an appointment with an ophthalmologist (eye specialist) who was treating her glaucoma. At the doctor's request, she was to have a follow-up visit in 2-4 weeks. Review of the clinical records revealed that although Resident #7 received her daily eye drops for glaucoma, her next visit to the eye specialist took place on 5/23/08, approximately 2 years later. An interview with the Director of Nursing on 12/9/08 confirmed these findings.	F 313			
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations during the survey, it was determined that the facility failed to maintain an environment free from accident hazards as evidenced by unlocked oxygen tanks. Additionally, based on the review of clinical records and other facility documents, the facility failed to implement interventions to reduce hazards and risks of injury from a fall for one (1)	F 323			

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F 323	Continued From page 18 resident (Resident #8) out of nineteen (19) sampled residents. Findings include: 1. The second floor oxygen room containing oxygen tanks, was observed unlocked on 12/3/08, 12/4/08 and 12/5/08. Findings were confirmed by the second floor nursing supervisor. 2. Review of Resident #8's clinical record revealed a nurse's note, dated 6/19/08 and timed 11:50 PM, that stated, "...found resident lying on the floor... Skin tear was noted to R (right) shin that measures 3 cm X 2 cm. ... Resident stated that she fell from the bed. Bed was noted in high position and no call bell within reach..." Review of Resident #8's Incident Report dated 6/19/08, included a witness statement from CNA#7 that stated, "... Resident's bed was all the way up and not in the lowest position and call bell was not in reach - string/cord needs to be longer..." Review of the 5 day follow-up report dated 6/23/08 stated that CNA #8, who was "... responsible for Resident #8 on that shift was counciled (sic), and instructed to make sure bed is always in low position with call bell in reach. Also maintenance requested to add enough cord to call light in order for resident to reach it." The facility failed to implement interventions to reduce hazards and risk of injury by failing to maintain Resident #8's bed in the low position and failing to provide a call bell of adequate length within her reach. Findings were confirmed with the Director of Nursing on 12/10/08.	F 323 F323	1.1 Oxygen room door is closed and has new lock installed. 1.2 All residents may be affected. 1.3 Supervisor's checklist adapted to check these doors for security. 1.4 DON or designee will report findings of Supervisor's Checklist to QA. 2.1 CNA has been counseled for leaving bed elevated. Call bell will be adjusted to meet adequate length. 2.2 All resident may be affected. 2.3 Nursing staff will be inserviced regarding resident safety. Supervisor's checklist has been adapted to check proper bed positioning and call bell length. 2.4 DON or designee will report findings of Supervisor's checklist to QA.		1/30/09 1/30/09 1/30/09 1/30/09 1/30/09 1/30/09 1/30/09
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must -	F 371			

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F 371	<p>Continued From page 19</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to protect food during preparation, storage and distribution. Findings include:</p> <p>The following findings were observed on 12/2/08, during a tour of the kitchen area with the Food Service Director (FSD):</p> <p>1. (a) Debris was observed under a storage rack in the dry storage room.</p> <p>(b) Raw shell eggs in cardboard flats were observed stored in racks over exposed produce in the walk-in refrigerator.</p> <p>(c) The handwashing sink in the dish room was observed blocked by a cart.</p> <p>(d) Wiping cloths were observed stored in buckets without sanitizer.</p> <p>(e) The sanitizer compartment of the warewashing sink had less than the 200 ppm concentration of quaternary ammonium sanitizer required to adequately sanitize food equipment.</p>	<p>F 371</p> <p>F371</p>	<p>1. Debris has been removed. Eggs will be kept on the bottom shelf. Sink will be free from obstruction. Cleaning cloths will be stored in sanitizer solution. Sanitizer has been corrected. Trash will be provided to ladies room. Soap dispenser will be replaced. Chemicals will be labeled. Caulk will be replaced. Formica borders will be secured and countertops sealed with caulk until replaced. 2nd floor pantry wall will be repaired. Soiled utensil tray has been removed. Measuring spoons will be stored in cabinets in pantry when not being used. Counter top in 3rd floor pantry will be sealed/caulked.</p> <p>2. All residents may be affected.</p> <p>3. Administrator or designee will conduct weekly tour to identify areas to be repaired.</p> <p>4. Administrator or designee will report findings of tour to QA.</p>	<p>1/30/09</p> <p>1/30/09</p> <p>1/30/09</p> <p>1/30/09</p>

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F 371	<p>Continued From page 20</p> <p>(f) The ladies bathroom lacked a trash can with a lid.</p> <p>(g) The soap dispenser in the men's bathroom was broken.</p> <p>(h) An unlabeled working bottle of a chemical was observed in the chemical storage room.</p> <p>(i) Peeling caulking was observed around the joint between the table holding the slicer and an adjacent refrigeration unit.</p> <p>The following findings were observed on 12/2/08 during a tour of the dining rooms and service kitchens on the second and third floors:</p> <p>2. (a) Formica borders on walls surrounding the hand sinks and juice machines in both dining rooms were pulling away from the walls.</p> <p>(b) The wall next to the steam table in the second floor service kitchen was damaged.</p> <p>(c) A soiled utensil tray holding serving utensils was observed on a shelf under the steam table in the third floor service kitchen.</p> <p>(d) Measuring spoons were observed laying in the beverage thickener stored on the counter in front of the steam table in the third floor dining room.</p> <p>(e) The counter top around the steam table in the third floor service kitchen was cracked.</p> <p>Findings were confirmed with the FSD, Director of Nursing (DON), Administrator and the Executive Director.</p>	F 371			
F 514	483.75(l)(1) CLINICAL RECORDS	F 514			

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F 514 SS=D	<p>Continued From page 21</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, observations and record review the facility failed to maintain clinical records that were complete and accurately documented for one (Resident #15) out of 19 sampled residents. Resident #15's Medication Administration Record (MAR) indicated that she received a healthshake on 12/5/08 that was not given and ice cream on 12/3/08, 12/4/08 and 12/5/08 that was not given.</p> <p>1. Review of Resident #15's Physician's Orders Sheet (POS), dated 12/08, revealed an order for "Healthshake, 1 serving PO (by mouth) 2 times a day, 9 AM and 8 PM."</p> <p>Observations on 12/5/08 revealed that Resident #15 did not receive her morning healthshake. In an interview with LPN#3 later that day, she stated that she did not give the resident a healthshake. She stated that she thought dietary gave the healthshakes, but was later told that it should have been given by nursing.</p>	F 514 F514	<p>1.1 Resident will receive health shake as ordered.</p> <p>1.2 All residents may be affected.</p> <p>1.3 Nursing staff will be inserviced regarding proper administration of health shakes. Health shakes will not be given at meals to avoid further confusion. Supplement Policy will be updated to include above. Sample of residents receiving supplements will be reviewed monthly by DON or designee. Health shakes consumption will be recorded on MAR.</p> <p>1.4 Findings of review will be reported to QA.</p> <p>2.1 Ice cream will be offered to resident as ordered.</p> <p>2.2 All residents may be affected.</p> <p>2.3 Dietary staff will be inserviced regarding diet card procedure. Dining room checklist will be completed by Dietary Manager or designee.</p> <p>2.4 Results of Dining Room Checklist will be reported to QA.</p>		<p>1/30/09</p> <p>1/30/09</p> <p>1/30/09</p> <p>1/30/09</p> <p>1/30/09</p> <p>1/30/09</p> <p>1/30/09</p> <p>1/30/09</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/22/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/10/2008
NAME OF PROVIDER OR SUPPLIER GILPIN HALL			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GILPIN AVENUE WILMINGTON, DE 19806		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 514	<p>Continued From page 22</p> <p>Resident #15's MAR, dated 12/08, indicated that the morning healthshake was given.</p> <p>Cross refer F309 example #2</p> <p>2. Review of Resident #15's POS, dated 12/08, revealed an order for ice cream at 12:00 Noon and 5:00 PM.</p> <p>Review of Resident #15's MAR, dated 12/08, indicated that she received ice cream at 12:00 noon on 12/3/08, 12/4/08 and 12/5/08, when in fact observations revealed that she did not receive ice cream at these meals.</p>	F 514			



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Director's Office

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DATE SURVEY COMPLETED: December 10, 2008

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201	The State Report incorporates by reference and also cites the findings specified in the Federal Report.	
3201.5.11	<p>Nursing Home Regulations for Skilled Care</p> <p>Kitchen and Food Storage Areas</p> <p>The Division of Public Health's Regulations Governing the Sanitation of Public Eating Places shall apply to institutions and are appended hereto.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on observations during the tour of the kitchen with the Food Service Director on 12/02/08, it was determined that the facility failed to comply with sections: 3-302.11 (A), 3-304.12, 3-304.14 (B), 4-202.16, 4-602.13, 4-703.11 (C), 5-205.11 (A), 5-501.17, 6-301.11, 6-501.12 (A) and 7-102.11 of the State of Delaware Food Code. Findings include:</p> <p>3-302.11 Packaged and Unpackaged Food – Separation, Packaging, and Segregation.*</p>	3201.5.11 Cross refer to CMS 2567-L survey date completed 12/10/08, F371.

Provider's Signature _____

Title _____

Date _____



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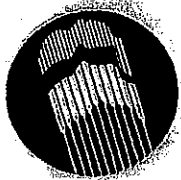
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NAME OF FACILITY: Gilpin Hall

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	<p>(A) Food shall be protected from cross contamination by:</p> <p>(1) Separating raw animal foods during storage, preparation, holding, and display from:</p> <p>(a) Raw ready-to-eat foods including other raw animal food such as fish for sushi or molluscan shellfish, or other raw ready-to-eat food such as vegetables, and</p> <p>(b) Cooked ready-to-eat food;</p> <p>This requirement is not as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 12/10/08, F371, Example #1 (b).</p> <p>3-304.12 In-Use Utensils, Between-Use Storage.</p> <p>During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored:</p> <p>(A) Except as specified under ¶ (B) of this section, in the food with their handles above the top of the food and the container;</p> <p>(B) On a clean portion of the food preparation table or cooking equipment only if the in-use utensils and the food-contact</p>	



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>surface of the food preparation table or cooking equipment are cleaned and sanitized at a frequency specified under §§ 4-602.11 and 4-702.11;</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to CMS 2567-L survey completed 12/10/08, F371, Example #2 (d).</p> <p>3-304.14 Wiping Cloths, Use Limitation.</p> <p>(C) Cloths used for wiping food spills shall be:</p> <p>(2) Wet and cleaned as specified under ¶ 4-802.11 (D), stored in a chemical sanitizer at a concentration specified in § 4-501.114, and used for wiping spills from food-contact and non-food-contact surfaces of equipment.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to CMS 2567-L survey completed 12/10/08, F371, Example #1 (d).</p> <p>4-202.16 Nonfood-Contact Surfaces.</p> <p>Non-food-contact surfaces shall be free of unnecessary ledges, projections, and crevices,</p>	



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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and designed and constructed to allow easy cleaning and to facilitate maintenance.

This requirement is not met as evidenced by:

Cross refer to CMS 2567-L survey date completed 12/10/08, F371, Example #1 (i) and Example #2 (a), (b) and (e).

4-602.13 Nonfood-Contact Surfaces.

Non-food-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.

This requirement is not as evidenced by:

Cross refer to CMS 2567-L survey completed 12/10/08, F371, Example #2 (c).

4-403.11 Hot Water and Chemical.*

After being cleaned, equipment food-contact surfaces and utensils shall be sanitized in:

(D) Chemical manual or mechanical operations, including the application of sanitizing chemicals by immersion, manual swabbing, brushing, or pressure spraying



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	<p>methods, using a solution as specified under §4-501.114 by providing:</p> <p>(3) An exposure time of at least 30 seconds for other chemical sanitizing solutions.</p> <p>This requirement is not as evidenced by:</p> <p>Cross refer to CMS 2567-L survey date completed 12/10/08, F371, Example #1 (e).</p> <p>5-501.17 Toilet Room Receptacle, Covered.</p> <p>A toilet used by females shall be provided with a covered receptacle for sanitary napkins.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to CMS 2567-L survey completed 12/10/08, F371, Example #1 (f).</p> <p>5-205.11 Using a Handwashing Facility.</p> <p>(A) A handwashing facility shall be maintained so that it is accessible at all times for employee use.</p> <p>This requirement is not met as evidenced by:</p>	



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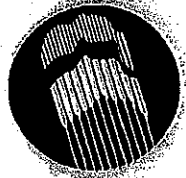
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	<p>Cross refer to CMS 2567-L survey date completed 12/10/08, F371, Example #1 (c).</p> <p>6-301.11 Handwashing Cleanser, Availability.</p> <p>Each handwashing lavatory or group of 2 adjacent lavatories shall be provided with a supply of hand cleaning liquid, powder, or bar soap.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to CMS 2567-L survey completed 12/10/08, F371, Example #1 (g).</p> <p>6-501.12 Cleaning, Frequency and Restrictions.</p> <p>(A) The physical facilities shall be cleaned as often as necessary to keep them clean.</p> <p>This requirement is not as evidenced by:</p> <p>Cross refer to CMS 2567-L survey completed 12/10/08, F371, Example #1 (a).</p> <p>7-102.11 Common Name.*</p>	



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.9.0	Working containers used for storing poisonous or toxic materials such as cleaners and sanitizing taken from bulk supplies shall be clearly and individually identified with the common name of the material.	
3201.9.1	This requirement is not met as evidenced by:	
	Cross refer to CMS 2567-L survey completed 12/10/08, F371, Example #1 (h).	
3201.9.1.1	Services to Patients	
	General Services	
	The skilled care nursing facility shall provide to all patients the care deemed necessary for their comfort, safety, nutritional requirements and general well-being.	
	This requirement is not met as evidenced by:	
	Cross refer to CMS 2567-L survey completed 12/10/08, F240 Examples #2, #3, and #4, F246, F309, F313 and F323	3201.9.1.1 Cross refer to CMS 2567-L survey date completed 12/10/08, F240, F246, F309, F313, F323.
3201.9.6	Food Service	
	A copy of the current week's menus – regular	
		3201.9.6 Cross refer to CMS 2567-L survey date completed 12/10/08, F240.



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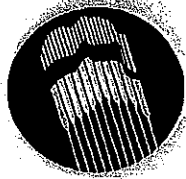
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16 Del. C., Chapter 11, Subchapter I	<p>and therapeutic – shall be posted in the kitchen and in a public area.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to CMS 2567-L survey completed 12/10/08, F240, Example #1.</p> <p>§ 1108. Posting of inspection summary and other information and public meetings.</p> <p>(a) Each facility shall prominently and conspicuously post for display in a public area of the facility that is readily available to residents, employees and visitors the following:</p> <p>(b) The notice relating to the compliance history of the facility must also be posted the facility as determined by regulations.</p> <p>(c) The compliance history information required to be maintained for public inspection by a facility under subsection (a)(6) of this section must be maintained in a well-lighted accessible location. The compliance history material must include all inspection reports produced for that facility during the preceding 3 year period. The information must be updated as each new inspection or other Department report is received by the facility.</p>	<p>16 Del. C., Chapter 11, Subchapter I</p> <ol style="list-style-type: none">1. Copies of the identified surveys will be placed into survey. 1/30/092. All residents may be affected. 1/30/093. Administrator will check for identified survey during monthly review of survey booklet. 1/30/094. Findings will be reported to QA. 1/30/09



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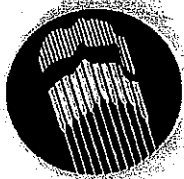
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16 Del. C., Chapter 11, Subchapter III	<p>This requirement is not met as evidenced by:</p> <p>Based on observations during the environmental tour on 12/3/08, it was determined that the facility failed to make the results of three years of State survey reports and two years of federal survey reports, including the plans of correction available for examination. Findings include:</p> <p>Review of the facility compliance history information revealed that the survey book located in the lobby on the first floor was missing the 2005 and 2006 federal reports. No state reports were available.</p> <p>§ 1121 Patient's rights</p> <p>(1) Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.</p> <p>This requirement is not met as evidenced by;</p> <p>Cross refer to CMS 2567-L survey, completed</p>	16 Del. C., Chapter 11, Subchapter III Cross refer to CMS 2567-L survey date completed 12/10/08, F241.



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	12/10/08, F241.	
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